wisconsin Medicaid update
department of health and family services
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To:

HMOs and Other Managed Care Programs

Nurses in Independent Practice

Respiratory Therapists

The Wisconsin Medicaid Update is the first source for provider information including Medicaid policy and billing information.

Wisconsin Medicaid is administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our web site at *www.dhfs.state.wi.us/medicaid*.

Review of billing instructions for nurses in independent practice and respiratory therapists

This Update is a review of instructions for billing dates, hours, and place of service on the HCFA 1500 claim form for nurses in independent practice providing private duty nursing (PDN) and respiratory care services (RCS), and respiratory therapists (RTs) providing RCS.

This Update reiterates current policy for completing element 24 of the HCFA 1500 claim form.

Completing element 24 of the HCFA 1500 claim form

In element 24 of the HCFA 1500 claim form, providers are required to enter the dates of service, place of service (POS), type of service, procedure codes, modifiers, diagnosis codes, charges, and days or units of time.

Billing one date of service:
To bill for one date of service, enter the date in element 24A in month, day, and year format (MM/DD/YY) in the "From" field. Complete all of element 24 for that date of service. Refer to Attachment 1 of this Update for complete instructions.

Billing multiple dates of service:
Providers may bill two, three, or four dates of service on one detail line if all of the information in element 24 is identical, including the number of hours worked per day and the number of hours at each place of service. Criteria for billing multiple dates on one detail line are found in Attachment 1, element 24A.

If you enter more than one date of service on one detail line, follow these instructions:

- Element 24A:
  1. Enter the first date of service in MM, DD, YY format in the "From" field.
  2. Enter each subsequent days' dates (up to three days) in the "To" field in the boxes labeled MM, DD, YY.

- Element 24B:
  Enter the appropriate place of service code. The place of service must be identical for all dates of service billed on one detail line.

- Elements 24 C-K:
  Complete according to directions on Attachment 1.

Example: Attachment 2 is a sample HCFA 1500 claim form illustrating how to complete element 24 to bill multiple dates of service on one detail line. In this example (detail 1) you worked four days (April 2-5) for a total of 32 hours. If you performed eight hours of service each day in the recipient's home, you bill those four dates of service on one detail line.

In element 24A, indicate the first date of service (04/02/99) in the "From" field. The subsequent three days' dates of service (03, 04, 05, without month and year) should be entered in sequential order in the "To" field.

Exception to billing multiple dates on one line

Shift spanning midnight:
If you work a shift that spans midnight, you should bill that shift on two detail lines if the number of hours worked before and after midnight are not equal. (If the number of hours worked before and after midnight are equal, you may bill them on one detail line.)

Example: Attachment 2 is a sample HCFA 1500 claim form illustrating how to complete element 24 to bill a shift that spans midnight. In this example (details 2 and 3), if you work 11:00 p.m. on March 9 to 7:00 a.m. on March 10, you must use two detail lines on the HCFA 1500 claim form. On one detail line, list March 9 as the date of service for the hour 11:00 p.m. to 12:00 midnight. On the next line, list March 10 as the date of service for the hours 12:00 a.m. to 7:00 a.m. One detail line cannot be used to indicate eight hours of service were provided on March 9.

Billing different places of service during one calendar day

If you provide services in two different places of service during one calendar day, you cannot bill them on one detail line.

Example: Attachment 2 (details 4 and 5) provides an example of billing multiple places of service. If, during one calendar day, you spend six hours providing service in the home (POS 4) and two hours providing service outside the home (POS 0), you must use two detail lines to bill for that date of service.

Rounding Guidelines for RCS and PDN Services

Time (in minutes)	Unit(s) billed
1 - 30	.5
31 - 44	.5
45 - 60	1.0
61 - 74	1.0
75 - 90	1.5
91 - 104	1.5
105 - 120	2.0
121 - 134	2.0
Etc.	Etc.

Providers using a billing service should give these instructions to the billing service.

Rounding guidelines for respiratory care services and private duty nursing

The total number of services (hours) billed for each detail line must be listed in element 24G. Private duty nursing (PDN) and respiratory care services (RCS) are rounded and billed in half-hour increments. The rounding guidelines for RCS and PDN services are:

1. If the visit is between 1 and 30 minutes in length, round the time up to 30 minutes and bill the service as a quantity of .5.
2. If the visit is over 30 minutes in length, round up or down to the nearest 30-minute increment, using the common rules of rounding listed in the table above.

Complete billing instructions

Nurses in independent practice and respiratory therapists (RTs) should refer to the billing instructions in Attachment 1. For nurses certified for PDN, these billing instructions

replace the instructions from Medical Assistance Provider Bulletin (MAPB) 092-009-T, dated December 28, 1992. For nurses and RTs certified for RCS, the billing instructions replace the instructions on pages 1T5-033 through 1T5-038 of Part T, Division 1, the RCS handbook. Providers using a billing service should give these instructions to the billing service. Always provide the billing service an accurate list of the hours and dates of service provided. As stated in HFS 106.02(9)(e), Wis. Admin. Code, "Each provider is solely responsible for the truthfulness, accuracy, timeliness and completeness of claims…," whether billing Wisconsin Medicaid themselves or through a billing service.

For more information, review the education teleconference network (ETN) titled "Nurses in Independent Practice, Session 3: Billing," held October 23, 1997. An audiotape and handouts are available. The ETN handouts are free and can be ordered by calling the Medicaid fiscal agent training coordinators at (608) 221-4746. The ETN audiotape cost is $8.20. For an audiotape of the ETN, write to:

Instructional Communication Systems
Pyle Center
702 Langdon Street
Madison, WI 53706

When ordering the handouts or audiotape, please specify the name and date of the ETN. For more information or questions about policy and billing, please call Provider Services at (800) 947-9627 or (608) 221-9883.

This information applies to fee-for-service Medicaid providers only. If you are a Medicaid managed care provider, contact your managed care organization for information about their procedures.

Attachment 1

NATIONAL HCFA 1500 CLAIM FORM INSTRUCTIONS FOR NURSES IN INDEPENDENT PRACTICE PROVIDING PRIVATE DUTY NURSE SERVICES

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless "not required" is specified.

Note: Medicaid providers should *always* verify recipient eligibility before rendering services.

ELEMENT 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "M" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER
Enter the recipient's 10-digit Medicaid identification number from the identification card. Do not indicate any other numbers unless the claim is a Medicare crossover claim. In this case, the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME
Enter the recipient's last name, first name, and middle initial as it appears on the Medicaid identification card.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55). Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME
Third-party insurance (commercial insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require third-party billing according to Appendix 18a of Part A, the all-provider handbook.

- When the provider has not billed other insurance because of "Other Coverage," the service does not require third party billing according to Appendix 18a of Part A, the all-provider handbook.

- If the recipient has no private insurance or dental (DEN) insurance only, this element must be left blank.

- When the recipient has Wausau Health Protection Plan (HPP), Blue Cross (BLU), Wisconsin Physicians Service (WPS), CHAMPUS (CHA), or some other (OTH) private insurance and the service requires third party billing according to Appendix 18a of Part A, the all-provider handbook, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the private insurer.
OI-Y	YES, the recipient has other coverage but it was not billed for reasons including, but not limited to: - Recipient denies coverage or will not cooperate. - The provider knows the service in question is noncovered by the carrier. - Insurance failed to respond to initial and follow-up claim. - Benefits not assignable or cannot get an assignment.

- When the recipient has an HMO or Wisconsin Physicians Service Health Maintenance Plan (HMP), one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services that are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER
This first box of this element is used by Wisconsin Medicaid for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing Wisconsin Medicaid. When

the recipient indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted. Hospitals, nursing homes, and home health agencies may use this disclaimer code when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient does not have Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A, the all-provider handbook, for further information regarding the submission of claims for dual entitlees.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE
(Not required since the provider automatically accepts assignment through Medicaid certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
When required, enter the referring or prescribing physician's name.

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the Wisconsin Medicaid provider number or license number of the referring provider.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE (not required)

ELEMENT 20 - OUTSIDE LAB (not required)

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
The *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. The diagnosis description is not required. List the primary diagnosis first. Claims for respiratory care services (RCS) must indicate a primary diagnosis of V46.1-ventilator.

Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION
Enter the seven-digit prior authorization (PA) number from the approved PA Request Form (PA/RF). Services authorized under multiple PAs must be billed on separate claim forms with their respective prior authorization numbers. Only one PA number can be billed on each claim.

ELEMENT 24A - DATE(S) OF SERVICE
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.

- When billing for two, three, or four dates of service, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.

- All services are billed using the same procedure code and modifier, if applicable.

- All procedures have the same type of service code.

- All procedures have the same place of service code.

- The same provider performed all procedures.

- The same diagnosis is applicable for each procedure.

- The charge for all procedures is identical (enter the total charge per detail line in element 24F).

- The number of services performed on each date of service is identical.

- All procedures have same HealthCheck or Family Planning indicator.

- All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE
Enter one of the following place of service codes:

Code	Description
0	Other (private duty nursing or private duty nursing ventilator-dependent only)
4	Home

ELEMENT 24C - TYPE OF SERVICE CODE
Enter type of service code "1" for each service.

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES
Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers.

If more than one nurse or respiratory therapist is providing services to a single recipient, the Prior Authorization Unit will assign a modifier with the approved procedure code. When the approved PA specifies a modifier, enter the two-digit modifier following the procedure code in the "Modifier" column.

ELEMENT 24E - DIAGNOSIS CODE
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES
Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS
Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed. Bill in half-hour increments.

ELEMENT 24H - EPSDT/FAMILY PLANNING (not required)

ELEMENT 24I - EMG
Enter an "E" for each procedure performed as an emergency, regardless of the place of service.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE
Enter the eight-digit, Medicaid provider number of the performing provider for each procedure if it is different than the billing provider number indicated in element 33.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A, the all-provider handbook, for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT
(Not required, provider automatically accepts assignment through Medicaid certification.)

ELEMENT 28 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER
The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

> ***NOTE:*** This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (not required)

ELEMENT 33 - PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Enter the name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medicaid provider number.

Attachment 2
Sample HCFA 1500 Claim

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Recipient, Im A.**

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): **609 Willow St.**

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: **Anytown** STATE: **WI**

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: **55555** TELEPHONE (Include Area Code): **(XXX) XXX-XXXX**

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Prescribing

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V46 1 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	04	02	99	03	04	05	4	1	W9041	05	1	XXX.XX	32				
2	03	09	99				4	1	W9041	05	1	XXX.XX	1.0				
3	03	10	99				4	1	W9041	05	1	XXX.XX	7.0				
4	04	05	99				4	1	W9041	05	1	XXX.XX	6.0				
5	04	05	99				0	1	W9041	05	1	XXX.XX	2.0				
6																	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.: 123JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ XXX.XX

29. AMOUNT PAID $ XXX.XX

30. BALANCE DUE $ XXX.XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized SIGNED **MM/DD/YY** DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 **86754321**

PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Detail 1: Billing multiple dates of service on one detail line ⇨

Details ⇨ 2 & 3: Billing a shift that spans midnight

Details ⇗ 4 & 5: Billing different places of service during one shift